

AUDIT/ DATE OF REVIEW/VISIT\_\_\_\_\_ CONDUCTED BY\_\_\_\_\_

**REHABILITATIVE MENTAL HEALTH  
FOR  
CHILDREN UNDER THE AUTHORITY OF DHS**

Division of Child and Family Services

**AUDIT TOOL FY2016  
Medicaid Residential Services  
DIS (REVISED 11/01/2014)**

AGENCY\_\_\_\_\_ YOUTH\_\_\_\_\_

TELEPHONE #\_\_\_\_\_ YOUTH MEDICAID #\_\_\_\_\_

MAILING ADDRESS\_\_\_\_\_

SITE ADDRESS\_\_\_\_\_

FAX#\_\_\_\_\_ E-MAIL \_\_\_\_\_

CONTACT PERSON\_\_\_\_\_

DATE OF ADMISSION \_\_\_\_\_ SERVICE CODES\_\_\_\_\_

DATE OF DISCHARGE\_\_\_\_\_

CASE MANAGER/REGION\_\_\_\_\_

CHEC\_\_\_\_\_ Dental\_\_\_\_\_ Vision\_\_\_\_\_  
(Within 30 days of Division custody and annually thereafter)

# PSYCHOLOGICAL EVALUATION

COMPLETED BY: \_\_\_\_\_ TITLE: PhD \_\_\_\_\_ MD \_\_\_\_\_

(IF STUDENT, CERTIFIED OR INTERN) SUPERVISED

BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

**TOTAL POSSIBLE POINTS: 13**

**Billing Codes:**      96101 \$120.95 (\$115.19)      Psychological Testing  
                                  96111 \$120.95 (\$115.19)      Developmental Testing  
                                  96116 \$120.95 (\$115.19)      Neurobehavioral Status Exam (limit 8 hrs./yr)  
                                  96118 \$120.95 (\$115.19)      Neuropsych Testing Battery (limit 8 hrs./yr)

(Medicaid 2-4)

## COMPLIANCE

## COMMENTS

1. Performed by a licensed physician, psychologist, certified psychology resident working under the supervision of a licensed psychologist, or supervised psychology student .		
2. Report includes the date(s), actual time(s), and duration(s) of testing.		
3. Report includes setting in which the testing was rendered.		
4. Written test reports include: a. Brief history b. Tests administered c. Test Scores d. Evaluation of test results e. Current functioning of the examinee f. Diagnoses g. Prognosis h. Specific treatment recommendations for behavioral/mental health services	       	
5. Report includes legible signature and title of the individual who rendered the service		
6. Report sent to Case Worker within 20 days of completion.		

# PSYCHIATRIC DIAGNOSTIC EVALUATION

COMPLETED BY: \_\_\_\_\_ TITLE: CMHC \_\_\_\_\_ LCSW \_\_\_\_\_ PhD \_\_\_\_\_ MD \_\_\_\_\_  
 APRN.(Advanced Practice Psychiatric  
 Mental Health Nurse Specialist) \_\_\_\_\_  
 Licensed Marriage & Family Therapist \_\_\_\_\_

(IF CERTIFIED OR INTERN) SUPERVISED BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

TOTAL POSSIBLE POINTS PER FILE: 8

**Billing Codes:** 90791 \$30.29/15 min. (\$28.85) PDE by Mental Health Therapist  
 90792 \$33.16/15 min. (\$31.15) PDE by MD/APRN  
 H0031 \$12.29/15 min. (\$11.78) Psychosocial portion by Non-therapist

(Medicaid 2-2, unless otherwise spec.)

## COMPLIANCE

## COMMENTS

1. Completed by a qualified mental health provider per Medicaid -5(B)		
2. Face to Face evaluation and includes date of service.		
3. Includes actual time of service, and duration.		
4. Includes the setting in which the service was rendered.		
5. Includes history, symptomology, and mental status.		
6. Includes a mental health diagnoses (DSM-IV/ICD-9) that is substantiated by the examination, etc.		
7. Includes summary of recommended behavioral/mental health treatment services. (must match with services provided)		
8. Includes legible signature and title of the individual who rendered the service.		

# TREATMENT PLAN

COMPLETED BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

TOTAL POSSIBLE POINTS PER FILE: 10 or 11

**Billing Codes:** 90791 \$30.29/15 min. (\$28.85) PDE by Mental Health Therapist  
 90792 \$33.16/15 min. (\$31.15) PDE by MD/APRN

(Medicaid 1-7, unless otherwise spec.) **COMPLIANCE** **COMMENTS**

1. Completed by a qualified mental health provider who either completed the examination, or who will be providing treatment. Medicaid 1-5(A)		
2. Completed at same time, or after the Diagnostic Interview Examination (within 30 days)		[Part II. Section VI.A.4.c(2-3)]
3. Completed prior to treatment and designed to improve and/or stabilize the client's condition.		[Part II. Section VI.A.4.c(4)]
4. Coordinated with the Division's Service Plan and Treatment Team.		[Part II. Section VI.A.4.c(2)]
5. Goals are individualized and reflect needs identified in the Examination.		
6. If PRS is included, there must be goals specific to each issue being addressed in PRS groups.		
7. Includes the method(s) to be used on each goal.		
8. Includes the frequency/duration for each method per goal.		
9. Includes the credentials of the staff responsible for providing the service.		
10. Discharge criteria per contract.		[Part II. Section VI.A.4.c.5(e)]
11. Copy provided to Case Manager within 15 days of completion.		(Part II. Section VI.A.4.c.7)

# TREATMENT PLAN REVIEW

COMPLETED BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

TOTAL POSSIBLE POINTS PER FILE: 7 – 10

<b>Billing codes:</b>	90791 \$30.29/15 min. (\$28.85)	PDE by Mental Health Therapist
	90792 \$33.16/15 min. (\$31.15)	PDE by MD/APRN
	90832 \$49.67 (\$47.30)	Individual Therapy (16-37 min.)
	90834 \$74.51 (\$70.96)	Individual Therapy (38-52 min.)
	90837 \$99.34 (\$94.61)	Individual Therapy (53-89 min.)
	99354 \$60.59 (\$57.70)	Individual Therapy (+135-164 min.)
	99355 \$60.59 (\$57.70)	Individual Therapy (+ 135-164 min.)
	90847 \$27.19/15 min. (\$23.65)	Family Therapy w/Client

(Medicaid 1-7 unless otherwise spec.) **COMPLIANCE**

**COMMENTS**

1. Completed by a qualified mental health provider who has sufficient face-to-face contact with the client to determine progress toward treatment goal(s). Medicaid 1-5(B)		
2. <i>The Plan is reviewed when there is a change in the client's condition.*</i>		
3. The review includes a written update of progress toward treatment goals contained in the treatment plan.		
4. Includes legible signature and credentials of the provider(s).		
5. A copy was sent to Case Manager within 15 days of the end of each review period.		

\*Examples of changes in condition that would merit the completion of a Treatment Plan Review (this is not an exhaustive list):

1. Step up/step down within same agency (i.e. group home to proctor).
2. Major family/living situation change.
3. Change in long term/transition planning.
4. Significant increase/decrease in behavioral problems.
5. Change in diagnosis(es).

## COMMENTS

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<p><b><u>Billing Codes:</u></b>  90849 \$6.33/15 min. (\$5.51) multi-family  90853 \$6.33/15 min. (\$5.51) other than multi-family</p> <ol style="list-style-type: none"> <li>1. Provided by a qualified mental health provider per Medicaid 1-5(B)</li> <li>2. Service must be face to face with a 1:12 ratio.</li> <li>3. Documentation includes the date</li> <li>4. Documentation includes the actual face to face time/duration per session</li> <li>5. Documentation includes the setting where the service was rendered.</li> <li>6. Documentation includes the goal heading from the youth's treatment plan that was addressed in the session</li> <li>7. Clinical note to include: <ol style="list-style-type: none"> <li>a) focus of the session (i.e. alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development)</li> <li>b) client's progress or if no progress documentation or reasons/barriers</li> </ol> </li> <li>8. Documentation includes legible signature and credentials of the person who rendered the service</li> </ol> <p><b>TOTAL POSSIBLE POINTS PER FILE: 9</b></p>		
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<p><b><u>PHARMACOLOGIC MANAGEMENT (Per session)</u></b></p> <p><b><u>Billing codes:</u></b></p> <p>99211 \$12.29/5 min. (\$11.70)  99212 \$26.72/10 min. (\$25.45)  99213 \$81.01/15 min.  99214 \$81.01/25 min.  99310 \$82.77/35 min. (\$78.83)  99215 \$88.88/40 min. (\$84.65)  M0064 \$35.41/hr. (RN)</p> <p>Who: Provided by a qualified mental health provider per Medicaid 2-8</p> <p>Definition: Service was face to face</p> <p>2.</p> <p>a. date and actual time of service  b. duration of the service  c. setting in which the service was rendered; and  d. specific service rendered (i.e. E/M services)</p> <p>3.</p> <p>a. health issues and medications reviewed/monitored, results of the review and progress toward related treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers;  b. dosage of medications as applicable;  c. summary of information provided;  d. if medications are administered, documentation of the medication(s) and method of administration; and</p> <p>4. signature and licensure or credentials of individual who rendered the service.</p> <p>TOTAL POSSIBLE POINTS PER FILE: 11</p>		<p>(Medicaid 2-8) <b>Effective JULY 2013</b></p>
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**\*Multiple Billing for Same-Service Contacts in a Day for each service meets the minimum time requirements:**

MCA (90791, 90792): Must be more than 8 minutes per session  
YF1, YF2, YF3, YFT (90832, 90834, 90837, 99354, 99355, 90846, 90847)  
Crisis Psychotherapy: (90832, 90839, 90840)  
YXH (96101, 96118, 96111, 96116): Must be more than 30 minutes per session  
YGT (90849, 90853): Must be more than 8 minutes per session  
PRS (H2017, H2014): Must be more than 8 minutes per session  
Med Mgmt Outpatient: (99211, 99212, 99213, 99214, 99215)  
Med Mgmt Psychiatric Residential: (99307, 99308, 99309, 99310)  
Med Mgmt RN: (M0064)

**Must be billed for each date of service on separate claim lines.**



<p><b><u>PSYCHOSOCIAL REHABILITATIVE SERVICES</u></b>  <b><u>Day Treatment Program/Residential Treatment</u></b>  (may follow guidelines for “other setting/individual PRS)  <b>Billing Codes:</b>  H2017 \$3.63/15 min. (\$3.16)  H2017 \$3.85/15 min.-U1 modifier, ages 0-12</p> <ol style="list-style-type: none"> <li>1. Must be provided by a qualified provider per Medicaid 2-11.</li> <li>2. Ratio of no more than 12 clients per provider or no more than 5 clients per provider in intensive PRS group</li> <li>3. For each date of participation in the program, documentation must include: <ol style="list-style-type: none"> <li>a) Name of each group the client participated (eg anger management, interpersonal relations, etc.)</li> <li>b) Date</li> <li>c) Actual time of the service</li> <li>d) Duration</li> <li>e) Setting in which the group was rendered.</li> </ol> </li> </ol> <p>2. <i>For each unique type of PRS group</i> during the immediate preceding two-week period, at a minimum one summary note that includes:</p> <ol style="list-style-type: none"> <li>a) Name of the group</li> <li>b) Treatment goal related to the group</li> <li>c) Progress toward goal and if no progress, documentation of reasons/barriers</li> <li>d) Signature and credentials of the individual who prepared the documentation</li> </ol> <p>TOTAL POSSIBLE POINTS PER FILE: 11</p>		(Medicaid 2-11)
<p><b><u>PSYCHOSOCIAL REHABILITATIVE SERVICES</u></b>  <b><u>Provided in other settings or to an Individual</u></b></p> <p><b>Billing Codes:</b>  H2017 \$3.63/15 min. (\$3.16)  H2017 \$3.85/15 min.-U1 modifier, ages 0-12  H2014 \$13.30/15 min. (\$12.94)-individual PRS</p> <ol style="list-style-type: none"> <li>1. Ratio of no more than 12 clients per provider (Part II E)</li> <li>2. For each unique type of PRS and for each group session, documentation must include: <ol style="list-style-type: none"> <li>a. Date</li> <li>b. Actual time of the service</li> <li>c. Duration</li> <li>d. Setting in which the group was rendered</li> <li>e. Specific type of group (i.e. anger management)</li> <li>f. Treatment goal(s) related to the group</li> <li>g. Progress toward goal and if no progress, documentation of reasons/barriers</li> <li>h. Signature and credentials of the individual who rendered the service.</li> </ol> </li> </ol> <p>TOTAL POSSIBLE POINTS PER FILE: 9</p>		(Medicaid 2-11)

<p><b><u>Intensive Supervision - Mentoring (non-Medicaid)</u></b></p> <p><b><u>Billing Code:</u></b> YIS \$3.31/15 min.</p> <ol style="list-style-type: none"> <li>1. Must be 21 years of age or older</li> <li>2. Must have HS diploma or GED</li> <li>3. Must have 3 written references from non-related persons</li> <li>4. Valid driver's license, verified annually</li> <li>5. Maintain auto insurance consistent with contract requirement</li> <li>6. Training is the same as a direct care staff</li> <li>7. Documentation: <ol style="list-style-type: none"> <li>a) Dates of services and activities</li> <li>b) Start and end times of services and activities</li> <li>c) Description of service/activity</li> <li>d) Name of individual who provided the service/activity</li> </ol> </li> <li>8. Copy of activity log given to Case Manager within 3 working days after the end of each month.</li> </ol> <p>TOTAL POSSIBLE POINTS PER FILE: 12</p>		
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<p><b><u>Day Group Skills Support Services (non-Medicaid)</u></b></p> <p><b><u>Billing Code:</u></b> DGS \$1.26/15 min.</p> <ol style="list-style-type: none"> <li>1. Must be 21 years of age or older</li> <li>2. Must have HS diploma or GED</li> <li>3. Must have 3 written references from non-related persons</li> <li>4. Valid driver's license, verified annually</li> <li>5. Maintain auto insurance consistent with contract requirement</li> <li>6. Training is the same as a direct care staff</li> <li>7. Documentation: <ol style="list-style-type: none"> <li>e) Dates of services and activities</li> <li>f) Start and end times of services and activities</li> <li>g) Description of service/activity</li> <li>h) Name of individual who provided the service/activity</li> </ol> </li> <li>8. Copy of activity log given to Case Manager within 3 working days after the end of each month.</li> <li>9. Must be provided in a licensed Day Treatment Program</li> <li>10. Staff ratio of no more than 8 clients ages 13 to 18 and no more than 5 clients for clients up through age 12.</li> </ol> <p>TOTAL POSSIBLE POINTS PER FILE: 14</p>		
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## OTHER CONTRACT REQUIREMENTS

<b>Part I: General Provisions</b> 1. Copy of PSA in file and services billed accordingly TOTAL POSSIBLE POINTS PER FILE: 1		
<b><u>Incident Reports:</u></b> 1. Documentation of Incident as required by DJJS Incident Report reference guide: 2. Reported and sent to DCFS official (CM or CM Sup.) within 24 hours. TOTAL POSSIBLE POINTS PER INCIDENT: 2		
<b><u>Discharge Report</u></b> 1. Date of discharge 2. Progress on Goals 3. Recommendations for future treatment needs 4. Report sent to case manager within 15 days of discharge 5. Copy of report in youth file  TOTAL POSSIBLE POINTS PER FILE: 5		

# PERSON-CENTERED SUPPORT PLAN

COMPLETED BY: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

TOTAL POSSIBLE POINTS PER FILE: 9

(Part II, Section II.C.1)

## COMPLIANCE

## COMMENTS

a. In coordination with DCFS CM & Team complete a Plan within 30 days of placement.		
b. (1) A behavior support plan when prescribed; (2) Psychotropic medication plan when prescribed; (3) Behavioral assessment; (4) Staff instruction sheet; and (5) A data collection sheet for skills training or other supports.		
c. The behavior support plan, when prescribed, shall include support strategies for the Client and support strategies for the Contractor. The support strategies shall identify measureable steps to address Client needs and the Client support strategies.		
d. Review the plan quarterly and update the plan based on the Client's progress and/or change in status in consultation with CM. Submit the Plan to the CM within 30 days of the end of the quarter.		
e. Submit a revised IRTS worksheet to the CM for approval and service authorization, is the review of the plan results in a need to change IRTS worksheet.		

## Documentation

TOTAL POSSIBLE POINTS PER FILE: 5

a. <u>Behavior Support Plan</u> : The Contractor shall create a written behavior support plan shall emphasize a positive approach with effective services designed to acquire and maintain adaptive behaviors and prevent problems behaviors.		
b. <u>Data Collection</u> : Chart the Client's behaviors for the month, to identify a pattern and/or triggers, and to help implement better behavior supports.		
c. <u>Psychotropic Medication Plan</u> : If prescribed include specific types of support strategies regarding usage, delivery and effects of psychotropic medications. The psychotropic medication plan content shall follow the DSPD Service Contract.		
d. <u>Staff Instruction Sheet</u> : For clients in a community living residential support home, develop a written staff instruction sheet to outline the Client's specific needs and activities, to be used by the direct care staff.		

<p><b><u>Onsite reconciliation of billings with client records</u></b>  <b>TOTAL POSSIBLE POINT PER BILLING: 1</b></p> <p><b>Psychological Testing</b>  96101 \$120.95 (\$115.19) Psychological Testing  96118 \$120.95 (\$115.19) Neuropsych Battery (limit 8 hrs/yr.)  96111 \$120.95 (\$115.19) Developmental Testing, Extended  96116 \$120.95 (\$115.19) Neurobehavioral Exam (limit 8 hrs/yr.)</p> <p><b>PDE/MHA</b>  90791 \$30.29/15 min. (\$28.85) Mental Health Therapist  90792 \$33.16/15 min. (\$31.15) MD/APRN  H0031 \$12.29/15 min. (\$11.78) Non-therapist(Psychosocial)</p> <p><b>Psychotherapy</b>  <i>Individual</i>  90832 \$49.67 (\$47.30) 16-37 min.  90834 \$74.51 (\$70.96) 38-52 min.  90837 \$99.34 (\$94.61) 53-89 min.  99354 \$60.59 (\$57.70) +135-164 min.  99355 \$60.59 (\$57.70) + 135-164 min.  90832 \$49.67 (\$47.30) crisis, 16-30 min.  90839 \$99.34 (\$94.61) crisis, 31-75 min.  90840 \$49.67 (\$47.30) crisis 75 min. +  <i>Family</i>  90847 \$27.19/15 min. (\$23.65)-w/client  90846 \$27.19/15 min. (\$23.65)-w/o client  <i>Group</i>  90849 \$6.33/15 min. (\$5.51) multi-family  90853 \$6.33/15 min. (\$5.51) other than multi-family</p> <p><b>Pharmacologic Management</b>  <i>Outpatient</i>  99211 \$12.29/5 min. (\$11.70)  99212 \$26.72/10 min. (\$25.45)  99213 \$81.01/15 min.  99214 \$81.01/25 min.  99310 \$82.77/35 min. (\$78.83)  99215 \$88.88/40 min. (\$84.65)  M0064 \$35.41/hr. (RN)</p> <p><b>PRS</b>  H2017 \$3.63/15 min. (\$3.16)  H2017 \$3.85/15 min.-U1 modifier, ages 0-12  H2014 \$13.30/15 min. (\$12.94)-individual PRS</p> <p><b>Non-Mental Health/Wrap Services</b>  YIS \$3.31/15 min.  DGS \$1.26/15 min.</p>		
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